NATIONAL INFUSION CENTER ASSOCIATION

March 1, 2017

The Honorable State Representative Sean Scanlon
Chairman
Insurance and Real Estate Committee
Legislative Office Building, Room 2800
Hartford, CT 06106

BY ELECTRONIC DELIVERY

Subject: Support of House Bill (H.B.) 7123

Dear Chairman Scanlon and Members of the House Committee on Insurance and Real Estate:

I am writing you on behalf of the National Infusion Center Association (NICA) and patients in Connecticut who are being forced — by their insurance plan — to switch from a medication that works to effectively manage their condition to one that may not, because it costs their insurance company less money. This cost-driven utilization management strategy is an egregious practice referred to as "non-medical switching."

Non-medical switching occurs when an insurer requires a stable health plan enrollee to switch from his or her current effective medication to a less costly alternative drug. Insurers achieve this outcome by either removing the medication from the formulary list, moving a drug to a higher cost tier, or increasing the out-of-pocket costs owed.

NICA supports switching a plan enrollee from a brand medication to a generic version of a drug that exhibits the same levels of effectiveness and safety. However, we strongly oppose policies that force stable patients to switch to a "therapeutic equivalent" medication (*i.e.*, an entirely different medication), especially in the case of biologics and other specialty provider-administered intravenous and injectable medications.

Established in 2010, NICA is a nonprofit advocacy organization that provides a national voice to patients relying on office-based Infusion Centers for the high-quality, cost-effective care they need. NICA and its infusion provider partners are committed to providing a safe, accessible and compassionate care setting for patients with autoimmune and chronic diseases that require provider-administered intravenous and/or injectable therapies.

Non-medical switching negatively impacts plan enrollees' health. Health care providers often work with plan enrollees for years to find a therapy that helps stabilize their conditions, manage their disease, or prevent re-emerging symptoms or the development of new side effects. Often, people living with epilepsy, diabetes, immunodeficiency, AIDS, cancer, mental health disorders,

and autoimmune diseases such as rheumatoid arthritis, inflammatory bowel disease, lupus, multiple sclerosis, psoriatic arthritis, and psoriasis just to name a few, must try multiple medications before finding one that is well tolerated and effective.

Forcing these stable plan enrollees to switch medications simply to save on cost can disrupt that carefully achieved equilibrium. Even the slightest variation in treatment protocol may trigger adverse reactions, adverse health outcomes, and/or negatively impact quality of life.[1] Additionally, when a patient switches off a medication and later switches back onto that same medication after failing other medication(s), that once effective treatment may lose its effectiveness due to increased tolerance or immunogenicity.

A switch that occurs at the beginning of a plan year is just as harmful as one that occurs mid-plan year. Long-term stability is critical for anyone struggling to manage a complex or chronic condition. Therefore, statutory patient protections against non-medical switching must limit switches that occur from year-to-year, as well as switches within the plan year, to have a positive and meaningful impact on all Connecticut residents with complex or chronic illnesses.

Patients must have access to a wide range of therapeutic options to find the right treatment protocol — the one that *works*. This is particularly important in the case of medications covered under the medical benefit, including intravenous immunoglobulin (IVIG) and biologic therapies for patients with primary immunodeficiency diseases and immune-mediated inflammatory conditions, like rheumatoid arthritis, Crohn's disease, ulcerative colitis, multiple sclerosis, psoriasis and lupus. It can take years for these patients to find a medication that successfully manages their debilitating condition(s). Failing to successfully manage the progression of disease in these patients typically requires expensive and highly invasive intervention (*e.g.*, joint replacement or bowel resection), which decreases quality of life and increases risk of adverse health outcomes.[2] As such, it is critical that these patients can rely on the statutory protections provided to them by their state to support uninterrupted access to a medication on which their condition is stable.

We believe that influencing the course of treatment for a patient constitutes the practice of medicine. Insurers should not be permitted to switch patients' medications mid-plan year for reasons not related to health. Furthermore, we believe that insurers should not be permitted to make formulary changes that result in non-medical switching for stable individuals who reenroll in existing health plans (*i.e.*, "grandfathered plans").

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[1] E. Nguyen et al., *Impact of Non-Medical Switching on Clinical and Economic Outcomes, Resource Utilization and Medication-Taking Behavior: A Systemic Literature Review*, 32(7) CURR. MED. RES. OPIN. 1281 (2016).

[2] *Cost-Motivated Treatment Changes: Implications for Non-Medical Switching*, Institute for Patient Access (2016).

Patient protections under existing statute in Connecticut must be enhanced to not only protect patients from non-medical switching during a plan year, but also during the reenrollment period so they are not left hunting for a new plan every year. Fortunately, there is legislation before your committee that will improve these patient protections during the plan year; however, it does not currently enhance protections against reenrollment switching.

Based on these concerns, we strongly support H.B 7123, which would enhance patient protections against non-medical switching practices, and respectfully ask that you include grandfathering language to further strengthen these protections for patients struggling to manage complex and/or chronic conditions. Thank you for time and consideration on this matter.

Sincerely,

BRIAN NYQUIST, MPH | EXECUTIVE DIRECTOR
NATIONAL INFUSION CENTER ASSOCIATION